Washington State Department of Health

For Office Use Only	
LICENSE NUMBER	DATE GRANTED

LICENSE #

APPLICATION FOR LICENSURE AS A PSYCHOLOGIST

Application for (check one): ☐ **National Written Examination and Oral Examination**
☐ **Transfer of National Written Examination**
☐ **Oral Examination by Endorsement (see Application Instructions)**

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. (See instructions to determine fees.) Make remittance payable to "Department of Health".

NOTE: APA stands for American Psychological Association. APPIC stands for Association of Psychology Postdoctoral and Internship Centers.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME — LAST — FIRST — MIDDLE NAME OR INITIAL

MAILING ADDRESS

CITY | STATE | ZIP | COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.) ( )

RESIDENCE TELEPHONE ( )

SOCIAL SECURITY NUMBER (REQUIRED FOR IDENTIFICATION PURPOSES ONLY.) — —

GENDER ☐ Female ☐ Male

BIRTHDATE (MO/DAY/YR) / /

PLACE OF BIRTH

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list

HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:
1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view - not profile
5. Instant Polaroid Photographs **not** acceptable

2. LICENSES IN OTHER JURISDICTIONS

List all jurisdictions where licenses are or were held. Specifically list licenses granted as temporary, or reciprocity, exemption, or similar with type, date, grantor, and if license is current.(attach additional 8 1/2 x 11 sheets if necessary.)

STATE OR OTHER JURISDICTION	PERMANENT OR TEMPORARY	LICENSE BY WRITTEN AND/OR ORAL EXAMINATION	LICENSE		CURRENTLY ACTIVE?
			YEAR ISSUED	NO.	

3. PERSONAL DATA

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

4. EDUCATION

DATE DOCTORAL PROGRAM BEGAN:

NAME AND LOCATION OF INSTITUTION GRANTING DOCTORAL DEGREE.

TYPE OF DOCTORAL PROGRAM (E.G. CLINICAL/COUNSELING, ETC.)

DATE ENTERED DOCTORAL PROGRAM WHICH GRANTED YOUR DOCTORAL DEGREE	DATE DEGREE RECEIVED (MONTH/YEAR)

NAME AND LOCATION OF PRE-DOCTORAL INTERNSHIP

Was your doctoral program APA approved at the time you received your doctoral degree? ☐ Yes ☐ No

Was your pre-doctoral internship APA approved? ☐ Yes ☐ No

Highest degree earned	Year

State in chronological order the name and location of each college, university, or professional school attended, the time spent in each, and if a graduate, the year of graduation. An official transcript is required of all graduate work, and is to be mailed directly from the college or university to the Department of Health, Examining Board of Psychology, PO Box 47869, Olympia, Washington 98504-7869. (Those seeking endorsement need not submit transcripts.)

NAME AND LOCATION OF INSTITUTION	DATES FROM (mo/day/yr)	DATES TO (mo/day/yr)	DATE GRADUATED (mo/day/yr)	DEGREE EARNED	MAJOR AREA OF STUDY	NUMBER OF SEMESTER/ QUARTER HOURS EARNED

MASTER 'S THESIS TITLE AND SUPERVISOR

DOCTORAL DISSERATION TITLE AND SUPERVISOR

Please check your areas of professional competency:

☐ Clinical/Counseling ☐ Neuropsychology ☐ Industrial/Organizational ☐ School/Educational
☐ Other (specify) _____

5. PREVIOUS APPLICATION

Have you ever taken a written or oral examination in psychology in the state of Washington? ☐ Yes ☐ No

Have you ever been denied a license as a psychologist in the state of Washington? ☐ Yes ☐ No

6. AIDS EDUCATION AND TRAINING ATTESTATION

I certify I have completed the minimum of 7 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

Applicant's Signature _____ Date _____

7. DOCUMENTATION OF EDUCATIONAL QUALIFICATIONS

NOTE: This section must be completed by all applicants who entered a doctoral program after **October 19, 1987** and whose academic program was not APA approved.

Please Type or Print Clearly

Name _____

Applicants for psychology licensure must have psychological coursework as specified in WAC 246-924-040. Because it is frequently difficult for the Board to determine from transcripts the coursework that fulfills various requirements, please fill in this outline to aid in our review. If any course listed does not specify clearly in its title the nature and/or content of the course e.g., Seminar; Issues in ...), please provide an official syllabus, official course outline, or statement from the professor documenting the content.

"Instructions should include history and systems; research design and methodology; statistics and psychometrics."

COURSEWORK	COURSE NUMBER AND TRANSCRIPT TITLE	YEAR	CREDITS	CHECK IF DOCUMENTATION IS ATTACHED
History and Systems				
Research Design Methodology				
Statistics				
Psychometrics				

The core program should also require each student to obtain an academic background or the following content areas (typically three or more semester hours, five or more quarter hours). The same credit cannot fulfill the requirements for two different areas. Course work must be at the graduate level.

Biological Bases of Behavior; e.g. physiological psychology, comparative, neuropsychology, sensation and perception, psychopharmacology.

COURSE NUMBER AND TRANSCRIPT TITLE	YEAR	CREDITS	CHECK IF DOCUMENTATION IS ATTACHED

7. (CONTINUED) DOCUMENTATION OF EDUCATIONAL QUALIFICATIONS

Cognitive-affective Bases of Behavior; e.g. learning, thinking, motivation, emotion.

COURSE NUMBER AND TRANSCRIPT TITLE	YEAR	CREDITS	CHECK IF DOCUMENTATION IS ATTACHED

Social Bases of Behavior; e.g. social psychology, group processes, organizational and systems theory.

COURSE NUMBER AND TRANSCRIPT TITLE	YEAR	CREDITS	CHECK IF DOCUMENTATION IS ATTACHED

Individual Differences; e.g. personality theory, human development, abnormal psychology.

COURSE NUMBER AND TRANSCRIPT TITLE	YEAR	CREDITS	CHECK IF DOCUMENTATION IS ATTACHED

Scientific and Professional Ethics

COURSE NUMBER AND TRANSCRIPT TITLE	YEAR	CREDITS	CHECK IF DOCUMENTATION IS ATTACHED

8. PRE-DOCTORAL SUPERVISED TRAINING WAC 246-924-050(3)

Note: This section must be completed if doctoral program was in an applied area (e.g. clinical), and Non APA Approved Program.

Practicum training is clinical (or other applied) experience during the doctoral program which is supervised, generally taken for credit, and often sited on the campus. These practica are intended to prepare the doctoral student for the internship year and are prerequisite to it. Please note that practicum requirements are entirely different and separate from the internship requirements. The program must include a set of coordinated practicum and internship experiences which total at least two semesters in the practicum setting, and additionally a "one-year" internship. A minimum of 300 hours of practicum, including 100 hours of scheduled individual supervision.

DATES		TOTAL NUMBER OF HOURS		NAME, TITLE, AND ADDRESS OF SUPERVISOR	DESCRIPTION OF SUPERVISED WORK ACTIVITIES, AND NATURE AND EXTENT OF SUPERVISION
FROM (mo/yr)	TO (mo/yr)	SUPERVISED WORK HOURS	DIRECT SUPERVISION		

For Applicants From Non-APA Approved Applied Programs Only

9. PRE-DOCTORAL INTERNSHIP TRAINING - WAC 246-924-040(3)

Name and location of Program ______________________________

Dates ______________________________

DATES		TOTAL NUMBER OF HOURS		NAME, TITLE, AND ADDRESS OF SUPERVISOR	DESCRIPTION OF SUPERVISED WORK ACTIVITIES, AND NATURE AND EXTENT OF SUPERVISION
FROM (mo/yr)	TO (mo/yr)	SUPERVISED WORK HOURS	DIRECT SUPERVISION		

10. FOR APPLICANTS FROM NON-APA APPROVED APPLIED DOCTORAL PROGRAMS ONLY

It is the applicant's responsibility to provide sufficient and clear documentation regarding the internship completed.

a. Was your internship APA approved or APPIC listed? ☐Yes ☐No

If **yes**, do not complete this form, instead, provide certificate of completion or letter from the internship director.

If **no**, please use the following as a check list to document that the internship completed meets the requirements of WAC 246-924-040(3).

b. Did your internship provide a planned programmed sequence of training experience to assure breadth and quality of training? ☐Yes ☐No

Please describe and include appropriate documentation (e.g. brochure, and/or descriptive letter from internship director).

_____

_____

_____

c. Did your internship have a clearly designated psychologist who was responsible for the integrity and quality of the program, and who is licensed by the state/province board of psychology examiners? ☐Yes ☐No

Please indicate the name and license number of the director.

Name _____ License number _____

d. Did your internship have two or more psychologists available as supervisors, at least one of whom was licensed as a psychologist? ☐Yes ☐No

Please indicate the names of at least two supervisors, (and license numbers if applicable).

Name _____ License number _____

Name _____ License number _____

e. Was your internship supervision provided by the person who was responsible for the cases being supervised? ☐Yes ☐No

Please explain (and document by brochure or letter from the director/supervisor) the relationship between the supervisor and the internship program.

_____

_____

_____

f. Was at least 75% of your internship supervision provided by psychologists? ☐Yes ☐No
Please document in a brochure or letter from your internship director/supervisor.

g. Was at least 25% of your time or internship spent in direct client contact (assessment and intervention)? ☐Yes ☐No
Please document in a brochure or letter from your internship director/supervisor.

h. Was there a minimum of two hours per week of regularly scheduled, formal, face to face individual supervision with the specific intent of dealing with the direct psychological services rendered by the intern? ☐Yes ☐No
Please document in a brochure or letter from your internship director/supervisor.

i. Was there a minimum of two hours of other learning activities (e.g. case conferences, seminars on applied issues, co-therapy with a staff person, including discussion, group supervision) ☐Yes ☐No
Please document in a brochure or letter from your internship director/supervisor.

j. Did your internship include supervision and therapy relating to ethics as an ongoing aspect of the program? ☐Yes ☐No
Please document in a brochure of letter from your internship director/supervisor.

k. Did trainees in your internship program have titles such as "intern", "resident", "fellow", or other designation of trainee status? ☐Yes ☐No
Please document in a brochure or letter from your internship director/supervisor.

l. Did your internship (at the time you were enrolled) have a written statement or brochure describing the goals and content of the internship, stating clear expectations regarding quality of trainee's work and made available to prospective interns? ☐Yes ☐No
Please provide a copy of the brochure.

m. Did your internship consist of at least 1500 hours completed within 24 months? ☐Yes ☐No
Please provide documentation in brochure or letter from supervisor.

11. POST-DOCTORAL SUPERVISED TRAINING WAC 246-924-060(3)

NOTE: Acceptable experience involves 1 hour of direct supervision for every 20 hours of work.

DATES		TOTAL NUMBER OF HOURS		NAME, TITLE, AND ADDRESS OF SUPERVISOR	DESCRIPTION OF SUPERVISED WORK ACTIVITIES, AND NATURE AND EXTENT OF SUPERVISION
FROM (mo/yr)	TO (mo/yr)	SUPERVISED WORK HOURS	DIRECT SUPERVISION		

12. APPLICANT'S ATTESTATION

I, _____, certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals institutions or organizations, my references, employers (past and present), business and professional associate (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certification to practice in the State of Washington.

Signature of Applicant _____ Date _____

Official Use Only

Washington State Records Center

Health Professions Quality Assurance Division
PO Box 1099
Olympia, WA 98507-1099

PROFESSIONAL REFERENCE FORM

Please type or print clearly

NOTE: Please be advised that upon receipt of written request, this form may be released to the applicant. However addresses and telephone numbers will not be released. This form may be duplicated.

_____ has applied for licensure as a psychologist in
NAME OF APPLICANT

the State of Washington and has given your name as a reference. Please return directly to: *Department of Health, Examining Board of Psychology, PO Box 47869, Olympia, Washington 98504-7869.*

YOUR NAME			
ORGANIZATION	POSITION		
ADDRESS	CITY	STATE	ZIP

I. Relationship to Candidate:

☐ Pre-doctoral Supervisor ☐ Post-doctoral Supervisor ☐ Professional Colleague

☐ Other (specify) _____

Approximate date of this relationship: From _____ To _____

Percent of applicant's time spent in psychological work: _____

Title of applicant's position and name of organization _____

_____

II. Describe briefly the applicant's duties as you knew them in the position listed above: _____

_____

_____

III. Please comment on the applicant's professional judgment, responsibility, integrity, and relations with professional peers and with clients.

_____

_____

_____

_____

IV. If you were a supervisor of the applicant's post-doctoral work, please complete the following:

A. Dates of post-doctoral supervision: From _____ To _____

B. Total number of hours of post-doctoral psychological work you supervised: _____

C. Total number of hours of face to face supervision you provided: _____

D. Was there one hour of supervision for every 20 hours? ☐ Yes ☐ No

Applicants are required to have one year of post-doctoral supervision consisting of a minimum of 1,500 supervised hours according to WAC 246-924-060 and 065.

V. Please check the areas in which you judge the candidate to be technically competent and able to meet reasonable standards in the profession of psychology. Please double check what you regard as the applicant's specialty area:

☐ Clinical/counseling ☐ Neuropsychology ☐ Industrial/organizational ☐ School/Educational

☐ Other (specify) _____

VI. Do you have any concerns in recommending this applicant for licensure in the state of Washington for independent practice? If yes, please comment specifically. Include any other information you consider relevant.

_____

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VII. Is there any other information about this candidate which you believe should be provided to the Examining Board of Psychology? If so, please explain. _____

_____

_____

_____

_____

_____

_____

_____

To the best of my knowledge I have answered the above questions truthly.

Are you licensed as a: ☐ Psychologist ☐ Psychiatrist ☐ Social Worker

In what state(s) or jurisdiction(s) are you licensed? _____

License Number: _____

Date of Original License: _____

Your Signature _____ Date _____

Thank you for your cooperation.
Washington State Examining Board of Psychology (360) 236-4910